



Washington State Department of
Health
Health Professions Quality Assurance
Hearing and Speech Program
P.O. Box 47869
Olympia, WA 98504-7869

Speech Language Pathologist Delegation of Supervision

NAME OF SUPERVISOR OF RECORD	LICENSE NUMBER
NAME OF PERMIT HOLDER	PERMIT NUMBER
SUPERVISOR'S BUSINESS ADDRESS	

CITY	STATE	ZIP	TELEPHONE ()
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Delegation to Speech Language Pathologist

NAME OF DELEGATED SPEECH LANGUAGE PATHOLOGIST

DELEGATED SPEECH LANGUAGE PATHOLOGIST'S SIGNATURE	DATE
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LICENSE NUMBER	FIRST ISSUE DATE
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BUSINESS ADDRESS

CITY	STATE	ZIP	TELEPHONE ()
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Duration of Training

From	To
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Delegated Supervisor's Attestation

I _____, do hereby certify that

NAME OF DELEGATED SUPERVISOR

NAME OF PERMIT HOLDER
will work under my supervision

performing all speech language pathology services during the interim permit period.

SIGNATURE OF DELEGATED SUPERVISOR

DATE

Approval _____

Denial _____